§ 435.201 Individuals included in optional groups.

(a) The agency may choose to cover as optional categorically needy any group or groups of the following individuals who are not receiving cash assistance and who meet the appropriate eligibility criteria for groups specified in the separate sections of this subpart:

(1) Aged individuals (65 years of age of older);

(2) Blind individuals (as defined in § 435.530);

(3) Disabled individuals (as defined in § 435.541);

(4) Individuals under age 21 (or, at State option, under age 20, 19, or 18) or reasonable classifications of these individuals;

(5) Specified relatives under section 406(b)(1) of the Act who have in their care an individual who is determined to be dependent (or would, if needy, be dependent) as specified in § 435.510; and

(6) Pregnant women.

(b) If the agency provides Medicaid to any individual in an optional group specified in paragraph (a) of this section, the agency must provide Medicaid to all individuals who apply and are found eligible to be members of that group.

(c) States that elect to use more restrictive eligibility requirements for Medicaid than the SSI requirements for any group or groups of aged, blind, and disabled individuals under § 435.121 must apply the specific requirements of § 435.230 in establishing eligibility of these groups of individuals as optional categorically needy.

[58 FR 4927, Jan. 19, 1993]

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§ 435.210 Individuals who meet the income and resource requirements of the cash assistance programs.

The agency may provide Medicaid to any group or groups of individuals specified in § 435.201 (a)(1) through (a)(3) and (a)(5) and (a)(6) who are not mandatory categorically needy, who meet the income and resource requirements of the appropriate cash assistance program for their status (that is, the State's approved AFDC plan or SSI, or optional State supplements in States that provide Medicaid to optional State supplement recipients).

[58 FR 4927, Jan. 19, 1993]

§ 435.211 Individuals who would be eligible for cash assistance if they were not in medical institutions.

The agency may provide Medicaid to any group or groups of individuals specified in § 435.201(a) who are in title XIX reimbursable medical institutions and who:

(a) Are ineligible for the cash assistance program appropriate for their status (that is, AFDC or SSI, or optional State supplements in States that provide Medicaid to optional State supplement recipients) because of lower income standards used under the program to determine eligibility for institutionalized individuals; but

(b) Would be eligible for aid or assistance under the State's approved AFDC plan, SSI, or an optional State supplement as specified in §§ 435.232 and 435.234 if they were not institutionalized.

[58 FR 4927, Jan. 19, 1993]

§ 435.212 Individuals who would be ineligible if they were not enrolled in an HMO.

The agency may provide that a recipient who is enrolled in a federally qualified HMO (under a risk contract as specified in § 434.20(a)(1) of this chapter) and who becomes ineligible for Medicaid is considered to continue to be eligible—

(a) For a period specified by the agency, ending no later than 6 months from the date of enrollment; and

(b) Except for family planning services (which the recipient may obtain from any qualified provider) only for services furnished to him or her as an HMO enrollee.

[56 FR 8849, Mar. 1, 1991]

§ 435.217 Individuals receiving home and community-based services.

The agency may provide Medicaid to any group or groups of individuals in the community who meet the following requirements:

(a) The group would be eligible for Medicaid if institutionalized.